Supreme Court, U.S.
FILED
JUN 0 1 2000
CLERK

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No. 99-1738

In the

Supreme Court of the United States

CHILDREN'S SEASHORE HOUSE,
Petitioner,

v.

MICHELE K. GUHL, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF THE RESPONDENTS IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Did the Court of Appeals for the Third Circuit and the district court correctly determine that petitioner had no standing to bring the 42 U.S.C. § 1983 complaint alleging violation of the provisions of Title XIX of the Social Security Act in regard to disproportionate share payments to out-of-state hospitals.

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STATUTORY PROVISIONS INVOLVED

Petitioner only set forth part of section 1923 of the Social Security Act, codified at 42 U.S.C. § 1396r-4, in its appendix. As the respondents refer to other portions of that statute in this brief, the entire section is reproduced at App., *infra*, 1a.

STATEMENT OF THE CASE

This interlocutory petition for a Writ of Certiorari seeks to appeal part of the decision of the Court of Appeals for the Third Circuit, finding that petitioner has no standing under 42 U.S.C. § 1983 to bring this action based upon the current hospital reimbursement provisions of Medicaid law.

A. The Action and Decision Below

The complaint in this matter was filed in the federal district court for the District of New Jersey on May 8, 1998, after the Boren Amendment was repealed by Congress and replaced by the Balanced Budget Act of 1997. It alleged claims pursuant to 42 U.S.C. § 1983 for alleged violations of Medicaid law and the Equal Protection Clause against officials of the State of New Jersey acting in their official capacity only. Consequently, the only relief sought and available is prospective injunctive relief, as any other relief would be barred by the Eleventh Amendment. *Will v. Michigan Dept. of State Police*, 491 U.S. 58 (1989).

On December 8, 1998, the district court granted the State's motion to dismiss for failure to state a cause of action. The district court held that Children's Seashore House had no standing to bring its claim based upon Medicaid Law and that its Equal Protection Clause claim was without merit.[1]

Children's Seashore House appealed to the United States Court of Appeals for the Third Circuit. On November

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[1] Children's Seashore House sought to amend its complaint to add a claim pursuant to the Commerce Clause which was never addressed by the district court.

30, 1999, the Third Circuit affirmed in part, reversed in part and remanded the matter back to the district court. The Third Circuit agreed with the district court that Children's Seashore House did not have standing to pursue its claim premised on the Medicaid Act, but found further fact finding was needed on the Equal Protection claim. In addition, the Third Circuit stated that on remand Children's Seashore House could renew its motion to assert its Commerce Clause claim. This matter is currently pending before the district court on Petitioner's claims pursuant to the Equal Protection Clause and the Commerce Clause.

B. Statutory Background

The Medicaid program is a joint federal-state program designed to provide medical assistance to individuals "whose income and resources are insufficient to meet the cost of necessary medical services." 42 U.S.C. § 1396. Although a state is not required to participate in the program, once a state has been accepted into the program, it must comply with the Medicaid statute and federal regulations. *Harris v. McRae*, 448 U.S. 297 (1980). As required by 42 U.S.C. § 1396a(a)(5), the Department of Human Services (DHS) has been designated as the single state agency responsible for administering the Medicaid Program in New Jersey; the Division of Medical Assistance and Health Services (DMAHS) is charged with responsibility for the daily operation of the program. N.J.S.A. 30:4D-3(c), 30:4D-5.

The State of New Jersey, in conformity with 42 U.S.C. § 1396a(a), must submit a State Plan to the United States Department of Health and Human Services (HHS) for approval. The State Plan describes the policy and methods used to set payment rates for each type of service included in the program in order to qualify for federal matching funds and to ensure that its program conforms to federal requirements. The State Plan, and any subsequent proposed amendment (State Plan Amendment or SPA) must meet federal requirements. 42 U.S.C. § 1396a(b); 42 C.F.R. §§ 430.10,

430.12. *See Rite Aid of Pennsylvania v. Houstoun*, 171 F.3d 842, 846 (3rd Cir. 1999). All initial State plans and amendments are approved or disapproved by the Health Care Financing Administration (HCFA), acting for the Secretary of HHS.

Prior to legislation enacted by Congress in 1980 and 1981, certain institutional providers, including hospitals, were reimbursed by state Medicaid agencies on a reasonable cost basis, 48 Fed. Reg. 56046 (1983). The 1981 legislation changed the standard for reimbursement of nursing and intermediate care facilities. Pub.L. No. 96-499, § 962(a) required that the rates paid to these providers through states' Medicaid programs be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." In 1981, the controlling statute, 42 U.S.C. § 1396a(a)(13)(A), was again amended to include hospitals, and to require, *inter alia*, that states "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs." Pub.L. No. 97-35, § 2173. This change is known as the "Boren Amendment." As amended, Section 1396a(a)(13)(A) provided in relevant part as follows:

> A State plan for medical assistance must-- ... provide-- ... for payment ... of the hospital ... services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs ...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the

> costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital ... and periodic audits by the State of such reports....42 U.S.C.A. § 1396a (West Supp.1989). [*West Virginia University Hospitals v. Casey*, 885 F.2d 11, 22 (3d Cir. 1989)].

Although the Secretary of Health and Human Services promulgated regulations designed to implement the Boren Amendment, the regulations did not include explicit criteria for federal review of states' methods and standards for establishing payment rates. Such a list, the Secretary concluded, might be viewed as imposing federal standards for payments rates, and as such would have been contrary to Congress' intent, which placed the responsibility for developing such rates upon the states, 48 Fed. Reg. 56049 (1983). The regulations only required that a State, in order to receive HCFA approval of a State plan change in payment methods and standards, must:

> (a)...make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (i) of this

section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) Findings. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) Payment rates.

(i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospital services--

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with

special needs...[42 C.F.R. § 447.253].[2]

A subsequent statute, 42 U.S.C. § 1396r-4, implementing the requirements of 42 U.S.C. § 1396a(a)(13)(A), was added by Congress on December 22, 1987. It required states to submit a SPA to the Secretary by July 1, 1988, defining disproportionate share hospitals, and providing for increased payments to those hospitals as of July 1, 1988. Pub. L. No. 100-203, Title IV, § 4112. [3]

On September 30, 1988, New Jersey submitted to HCFA SPA 88-29, which was intended to comport with 42 U.S.C. § 1396r-4. This SPA covered disproportionate share ("DSH") payments to various types of hospitals. It indicated that New Jersey had a statewide pooling arrangement in accordance with 42 U.S.C. § 1396r-4(e), and stated that New Jersey would "reimburse disproportionate share hospitals located in a state other than New Jersey according to the approved Title XIX (Medicaid) reimbursement methodology in the state in which the hospital is located." SPA 88-29 was

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[2] HCFA has proposed to amend the regulations to remove this entire provision as it is inconsistent with the Balanced Budget Act of 1997, discussed *infra*. 64 Fed.Reg. 54263 (1999).

[3] Also in 1988, several amendments were made to 42 U.S.C. § 1396r-4, adding language which created an exception to the original requirements imposed by that statute. New Jersey and other states that met certain criteria came under § 1396r-4(e), captioned "special rule," which permitted states to limit DSH payments to acute care hospitals involved in a statewide "pooling arrangement." The statewide pooling arrangement referred to in the "special rule" was a function of New Jersey's unique hospital rate-setting system. At the time 42 U.S.C. § 1396r-4(e) was enacted, New Jersey hospital rates were set by statute, under an "all-payor" system which set the rates charged by hospitals for the various paying entities. L.1978 c. 83 (Chapter 83). This rate system included a statewide pooling arrangement, whereby all hospitals collected an assessment to reimburse those hospitals which paid for a "disproportionate share" of "uncompensated care."

later split into four parts; the out-of-state portion was designated as SPA 88-29(d).[4]

In 1992, New Jersey's hospital rate setting system was invalidated by the decision in *United Wire, Metal & Machine Health and Welfare Fund, et al. v. Morristown Memorial Hosp.*, 793 F.Supp. 524, (D.N.J. 1992), and the system was replaced by the State Legislature.[5]

Under the Health Care Reform Act of 1992, L. 1992, c. 160, (Chapter 160), N.J.S.A. 26:2H-18.51 *et seq.*, effective January 1, 1993, the State replaced the rate-setting system with a deregulated, free market system by calendar year 1994 (1993 served as a transition year). In enacting Chapter 160, the Legislature recognized a "need to continue this State's current system of providing disproportionate share payments to hospitals in the State," and thus created a funding source for the State's hospitals. N.J.S.A. 26:2H-18.51(c). Under Chapter 160, disproportionate share hospitals are designated as such by the Commissioner of Human Services. N.J.S.A. 26:2H-18.52. The actual payment of the charity care subsidy, because it constitutes a DSH payment, is done through DMAHS, so that the State can then submit claims for federal financial participation (FFP). While the exact formulas for distributing charity care have changed on several occasions since 1992, as the result of legislative amendments, the basic concept has remained unchanged.

Charity care payments, including DSH payments, are made from the Health Care Subsidy Fund created by Chapter 160. The Fund is a "nonlapsing fund" dedicated for

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[4] As explained *infra* at n.8, this SPA was superseded the same day it was approved.

[5] The issue in *United Wire* was unrelated to any issues in this matter. The decision in *United Wire* was overturned in *United Wire, etc. v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3rd Cir. 1993), *cert. denied sub nom, New Jersey Carpenters Welfare Fund v. Dunston*, 510 U.S. 944 (1993), but the State Legislature had already changed the payment system.

use by the State to (among other things) distribute charity care subsidy payments to hospitals. N.J.S.A. 26:2H-18.58(a). Funding for these charity care payments currently comes from several sources as determined by the Legislature. N.J.S.A. 26:2H-18.58(a), N.J.S.A. 26:2H-18.58c. In each year since 1993, the Legislature has provided a specific, set amount to be distributed. This fund is distributed to in-state hospitals pursuant to specific statutory formulas (which have varied from year to year). The formulas do two things: first, they identify which particular acute care hospitals will be eligible in a given year, and second, they determine how the limited subsidy amount for that year will be distributed among those eligible hospitals. *See* N.J.S.A. 26:2H-18.59, and 59e. Not every acute care hospital in the State is eligible for or receives a charity care subsidy in a given year. Nor does the subsidy act as a strict "reimbursement," covering all of a hospital's charity care expenses. Rather, it represents a particular hospital's percentage of the limited State-wide subsidy amount, as set by the Legislature for that year.

Certain hospitals also receive an additional DSH payment adjustment from the Hospital Relief Subsidy Fund. N.J.A.C. 10:52-8.2(a)(4). This additional payment is based upon the facility's percentage of clients with AIDS, tuberculosis, substance abuse and addiction and complex birth.

During the time that New Jersey was revising its hospital rate setting methodology, and after it had been informed by HCFA that it did not need to make DSH payments to out-of-state hospitals,[6] the State stopped making

[6] DMAHS Director Saul M. Kilstein was informed by William L. Engelhardt, Acting Associate Regional Administrator of HCFA, in a letter dated June 21, 1993, that the State could, if it wished, withdraw SPA 88-29(d) (which had not yet been approved by HCFA), because it was not required to make DSH payments to hospitals outside of the State's DSH pool, pursuant to 42 U.S.C. § 1396r-4(e).

DSH payments to out-of-state hospitals, on or about July 1, 1993.[7]

An amended SPA concerning, *inter alia*, DSH payments to out-of-state hospitals, SPA 96-30, was submitted to HCFA on or about September 30, 1996. This SPA was subsequently divided into two separate SPAs, and the part that concerned DSH payments to out-of-state hospitals was redesignated as SPA 96-30B. That SPA states that "[t]he New Jersey Medicaid Program will not make disproportionate share hospital payments to any facility located in a state other than New Jersey." It was approved by HCFA on June 30, 1997, and had an effective date of September 20, 1996.[8]

The most significant event for purposes of this matter occurred on August 5, 1997 when President Clinton signed the Balanced Budget Act of 1997 (BBA). Section 4711 of the BBA replaced the Boren requirements with a new Section 1902(a)(13)(A) of the Social Security Act. The new statute requires the State plan to provide

> (A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services

[7] On page 5 of its petition, Children's Seashore House asserts the amount it believes it would have been entitled to in DSH payments from New Jersey during fiscal years 1996-1999. These figures were neither presented to the district court nor the Court of Appeals below and the respondent contests the accuracy of those amounts. Moreover, the complaint in this matter only seeks prospective relief, as the Eleventh Amendment would bar any claim for retroactive monetary damages, and the complaint was not filed until May 8, 1998, after the statutory changes repealing the Boren Amendment.

[8] On that same date, June 30, 1997, HCFA also approved SPA 88-29(d), with an effective date July 1, 1988. However, SPA 88-29(d) was immediately superseded by SPA 96-30B.

> of intermediate care facilities for the mentally retarded under which --
>
> (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
>
> (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
>
> (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and
>
> (iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs... [42 U.S.C. § 1936a(a)(13)(A)].[9]

Thus, the State no longer must make "findings" and "assurances" to the Secretary that the reimbursement rates are "reasonable and adequate" to meet the costs which must be incurred by "efficiently and economically operated facilities"

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[9] The BBA was signed into law on August 5, 1997, and these provisions apply to services furnished on or after October 1, 1997. Pub. L. No. 105-33, § 4711(d).

in order to provide care and services in conformity with applicable laws, regulations and quality and safety standards or to assure that individuals eligible for medical assistance have "reasonable access" to inpatient hospital services of adequate quality. Also removed is the requirement for periodic audits.

The BBA also set state-specific DSH allotments. Now codified at 42 U.S.C. § 1396r-4(f), states' DSH allotments were changed so that set amounts are provided each year beginning with Fiscal Year 1998. Congress reached a decision about how much each individual state was entitled to receive and there is no evidence that it included in its calculations that any state be required to give away significant portions of its DSH allotment to other states.

After the enactment of the BBA and in accord with the public process requirements of the BBA, the State adopted a regulation, N.J.A.C. 10:52-4.4(b), which provides that "[t]he Division shall not reimburse out-of-State hospitals for disproportionate share hospital (DSH) payments even if the DSH payments are included in the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located." N.J.A.C. 10:52-4.4(b) was proposed on April 6, 1998, 30 N.J.R. 1258(a), and adopted on June 18, 1998, effective July 20, 1998, 30 N.J.R. 2653(a), following the public comment period.[10]

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[10] The State did not actually have to comply with the public notice requirements. HCFA has interpreted the statutory language of the BBA to mean that States are not required to subject their existing rates to a public process. *See*, December 10, 1997 letter to State Medicaid Directors, from Sally K. Richardson, 18a. This interpretation is entitled to deference. *See, e.g., Planned Parenthood Affiliates of Michigan v. Engles*, 73 F.3d 634 (6th Cir. 1996), discussing a similar letter from Sally K. Richardson which was also sent to all state Medicaid Directors, and noting that the court would "accord deference to this reasonable agency interpretation of the statutory requirements of Medicaid" (*Id.* at 638, citations omitted).

REASONS FOR DENYING WRIT

In this case, petitioner Children's Seashore House ("CSH") is not challenging the rates it receives for treating Medicaid recipients from New Jersey as inadequate. Rather, petitioner is challenging New Jersey's refusal to give it an extra payment, known as a DSH payment.[11] The DSH payment is not payment for services rendered and is not related to medical care. Rather, it is a subsidy to compensate a qualifying hospital for the high percentage of otherwise uncompensated care provided by the hospital. Petitioner already receives a DSH payment from its home state, Pennsylvania, which must take into account all charity care provided by CSH, including those charity care patients it treats from other states. 55 Fed.Reg. at 10079 (1990), 21a.

The courts below correctly held that CSH did not have standing to pursue this 42 U.S.C. § 1983 action predicated upon an alleged violation of Medicaid law. Following the repeal of the Boren Amendment, the new statutory scheme does not impose a binding obligation on New Jersey to make any "payments" to hospitals. The only requirement is that the State have "a public process" for determination of rates of payment. Consequently, as the three-prong test enunciated by this court in *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106 (1989) and *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997), to determine whether a plaintiff has standing to bring this action has not been met, the courts below properly dismissed the claim, and there is no basis for granting certiorari.

In addition, petitioner posits a split in authority based upon this case and the Ninth Circuit's split decision in

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[11] Petitioner's allegation in footnote 9 on page 13 of its petition that it recently reduced its licensed inpatient beds due to Medicaid reimbursement reductions was never presented to the district court nor the Court of Appeals below and the respondent does not admit that this is an established fact. Moreover, this matter only concerns DSH payments, not payment rates in general.

Children's Hosp. and Health Ctr v. Belshe, 188 F.3d 1090 (9th Cir. 1999), *petition for certiorari filed*, 68 U.S.L.W. 3595 (U.S. Mar. 9, 2000)(No. 99-1497). However, the matter in the Ninth Circuit was originally filed in 1995, before the enactment of the BBA. In contrast, the case at bar was filed in May 1998, after the enactment of the BBA, and the petitioner waived its argument that the Boren Amendment still applied on appeal to the circuit court. Moreover, the Ninth Circuit never addressed the standing issue present in this matter. In addition, contrary to California, New Jersey followed the public process required by the BBA. Therefore, under either the Ninth Circuit's analysis or the Third Circuit's analysis, the result would be the same and there is no irreconcilable split meriting the attention of this Court. Finally, the circuit court did not apply the BBA retroactively as this matter was filed after the BBA was in effect. Consequently, a circuit court decision as to whether hospitals can continue to sue under the repealed-Boren Amendment is irrelevant to the case at bar.

Furthermore, petitioner's argument regarding the "social and financial" need for a private cause of action to enforce the DSH provisions is not an adequate reason to grant certiorari. Hospitals do not have standing to sue pursuant to § 1983 in accordance with the well-established test for making such determination. Consequently, there is no basis for granting certiorari based upon public policy considerations best left to the legislative action.

Lastly, this is an appeal of an interlocutory order. The matter is currently proceeding in the district court following the remand by the Third Circuit. There is no pressing need for this Court to hear this matter on an interlocutory basis.

I. The Decision Below Correctly Determined That CSH Had No Standing to Bring this Lawsuit

The courts below correctly held that CSH does not have standing to bring this lawsuit pursuant to 42 U.S.C. § 1983. Consequently, this petition is without merit.

"Section 1983 provides a cause of action for 'the deprivation of any rights, privileges, or immunities secured by the Constitution and laws' of the United States." *Wilder v. Virginia Hospital Assoc.*, 496 U.S. 498, 508 (1990). Section 1983 provides a cause of action for violations of federal statutes as well as the Constitution. *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980). However, a plaintiff will not be permitted to sue under § 1983 where the statute does not create enforceable rights, privileges or immunities within the meaning of § 1983 or where Congress has foreclosed such enforcement in the statute in the enactment itself. *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 423 (1987).

In order to determine whether a federal law creates a "federal right" that is enforceable under § 1983, courts apply a three-prong test. First, the court must determine whether "the provision in question was intend[ed] to benefit the putative plaintiff." *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106 (1989) (citations and internal quotations omitted). Second, if the provision was intended to benefit the putative plaintiff, the court must determine whether the provision merely reflects a "congressional preference" for a certain kind of conduct rather than a binding obligation on the governmental unit. Only a binding obligation is enforceable. *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 19 (1981). Third, there is no enforceable right where the interest the plaintiff asserts is "'too vague and amorphous'" such that it is "'beyond the competence of the judiciary to enforce.'" *Golden State, supra*, 493 U.S. at 106, quoting *Wright, supra*, 479 U.S. at 431-32. *See also Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997).

A. Hospitals Are Not the Intended Beneficiary

Applying the three-prong test in this case, it is clear that health care providers are no longer the intended beneficiaries of the reimbursement system. Contrary to the prior language of the Boren Amendment which required the state plan to provide for "payment," *Wilder*, 496 U.S. at 510, the new legislative scheme only requires the state plan to provide for "a public process" for determinations of rates of payment. 42 U.S.C. § 1396a(a)(13)(A). Thus, the first prong of the three prong test -- that health care providers are the intended beneficiaries -- is not met.[12]

B. The BBA Does Not Impose a Binding Obligation on the States to Make DSH Payments to Hospitals

Even assuming *arguendo* that the first prong could be met, the second prong -- whether the legislative scheme imposes a binding obligation on the States -- cannot be met. First, the only binding obligation imposed by the new scheme is to have a "public process" in place. 42 U.S.C. § 1396a(a)(13)(A). While that process includes publication of proposed and final rates, along with the underlying methodologies for establishing those rates and the justifications for those rates, there is no requirement as there was with the Boren Amendment that the states make findings and assurances that the rates are "reasonable and adequate." As stated by the Third Circuit

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[12] Even if health care providers are still intended beneficiaries, the State does not concede that out-of-state providers, as opposed to in-state providers, are the intended beneficiaries. Indeed, as set forth below, HCFA has taken the position that the hospital reimbursement provisions do not apply to out-of-state providers.

> [B]y replacing the Boren Amendment with a requirment that a State establish a public process by which its rates would be determined, Congress has removed a party's ability to enforce any substantive right. [*Children's Seashore House v. Waldman*, 197 F.3d 654, 659 (3d Cir. 1999) (citations omitted)].

Nor does 42 U.S.C. § 1396r-4 create a binding obligation on the States. Again, as the Third Circuit noted,

> [42 U.S.C. §1396]r-4 imposes neither procedural nor substantive requirements on a state that provide a basis for CSH to press its claims. Rather, r-4 is a definitional provision that describes certain procedures that a state must satisfy, such as submitting a qualifying plan to the Secretary of Health and Human Services by a certain date to establish an adequate state disproportionate share hospital adjustment plan. 42 U.S.C. § 1396r-4(a). Moreover, r-4 sets the parameters of what is a DSH, what constitutes an adequate payment adjustment, and what limits are placed on federal financial participation and on state allotments for each year. We are satisfied that CSH cannot predicate its claim on these provisions. [*Children's Seashore House*, 197 F.3d at 659-60].

The legislative history of the BBA makes clear that in repealing the Boren Amendment, Congress intended to foreclose further lawsuits against the states. CSH's assertions to the contrary notwithstanding, the amendment was designed to free states from excessive federal oversight, and to eliminate the use of the Boren Amendment by hospitals and nursing facilities as a basis for seeking judicial review as to the adequacy of the rates established by the states. The House Report explicitly declared, "It is the Committee intention that, following enactment of this Act, neither this nor any other provision of Section 1902 will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive." H.R. Rep. No. 110-149, at 591. That report also noted that under the Boren Amendment, "[a] number of courts found that state systems failed to meet the test of reasonableness and some states have had to increase payments to these providers as a result of these judicial interpretations." H.R. Rep. No. 149, *supra*, at 591, *accord*, H.R. Conf. Rep. No. 217., 105th Cong., 1st Sess. 867 (1997). "The Boren amendment has produced endless lawsuits ... Repealing the Boren amendment takes it out of the courts." Cong. Rec. S6305 (June 25, 1997), statement of Sen. Gramm.

House Conference Report No. 105-217 of July 30, 1997, the House/Senate conference agreement dealing with the Boren Amendment, taken as a whole, demonstrates a clear intent to repeal the Boren Amendment, and does not support the interpretation given by petitioner. The statement of the current law in the House Report (prior to the adoption of the BBA) acknowledges that courts were invalidating states' plans, and both the House and Senate reports state the intent to repeal the Boren Amendment. *See generally United States v. Congress of Industrial Organizations*, 335 U.S. 106, 112-13 (1948)(remedial laws are to be interpreted in light of previous experience and prior enactments).

Contrary to petitioner's argument that the BBA strengthened the DSH provisions, the final version of the BBA did not adopt the language of the House version which

specifically required that states take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs, and make assurances that the average level of payments made to hospitals would not drop for an 18 month period. A fair reading of the legislative history supports the State's position that the BBA was intended to limit suits brought under the Boren Amendment. *HCMF Corp. v. Gilmore*, 26 F.Supp.2d 873, 879 (W.D. Virginia 1998) ("The Balanced Budget Act of 1997 replaced the repealed Boren Amendments standard with a public notice process for states to follow in setting payment rates. There can be but one reasonable conclusion from Congress's action: Congress precluded a right of action under § 1983 for reimbursement claims for services rendered on or after October 1.")

Even if there is a binding obligation to make DSH payments to in-state hospitals, the language of § 1396r-4 simply does not indicate any requirement to make DSH payments to out-of-state providers. It is well settled that "[i]n statutory interpretation, the starting point is always 'the language [of the statute] itself.'" *Queen of Angels/Hollywood Presbyterian Medical Ctr. v. Shalala*, 65 F.3d 1472, 1477 (9th Cir. 1995)(citations omitted). Under step one of the now familiar two-part test enunciated in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984), a reviewing court first determines "whether Congress has spoken directly to the precise question at issue." *Id.* at 842. If the intent of Congress is clear, that ends the inquiry, because both the Court and the Secretary "must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43.

The language of § 1396r-4 nowhere indicates any requirement that out-of-state providers should be considered in implementing the statute. To the contrary, it refers to hospitals "in the state," 42 U.S.C. § 1396r-4(b)(1)(A), (defining a DSH institution); hospitals "in a state," 42 U.S.C. § 1396r-4(f)(1)(A); the "statewide" arithmatic mean, 42 U.S.C. § 1396r-4(f)(1)(A)(I)(b); the utilization rate "for all

hospitals in the state" 42 U.S.C. § 1396r-4(f)(1)(D); and in 42 U.S.C. § 1396r-4(e), the "statewide" pooling arrangement. Especially significant is Congress' determination when enacting the BBA to provide for specific state limits on the amount of DSH each state is entitled to receive. 42 U.S.C. § 1396r-4(f). If Congress' intent was to include out-of-state providers in these calculations, it could have made this point explicitly as it did in § 1396a(a)(16), requiring coverage of services provided to recipients outside of their home state. "[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23 (1983)(citations omitted). The Court should not expand the coverage of the statute, especially in light of the significant policy implications. *See United States v. Stephens*, 208 F.2d 105, 107 (5th Cir.1953) ("[C]ourts cannot, upon the pretence [sic] of construing [a statute], enlarge its coverage to bring within it those not expressly or by clear intendment embraced within its terms.").

Moreover, the Secretary has interpreted § 1396r-4 not to apply to out-of-state providers. It is the Secretary's position that DSH payments need not be made to out-of-State providers because the Medicaid statute does not require that DSH payments be used for "medical assistance" or any other Medicaid-related expenditure, but that the hospital can use the money for any purpose. *See* Brief of United States as *Amicus Curiae*, attorneys for the Secretary of Health and Human Services, in *Children's Hospital and Medical Center v. Belshe*, Docket No. C 95-1076 MHP (N.D. Cal.), at p.17 n.6. [13] Further evidence of the Secretary's position on this

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[13] In a split decision, the Ninth Circuit affirmed the district court's opinion in that matter, finding that the Boren Amendment applied to out-of-state providers notwithstanding the Secretary's interpretation to the contrary. *Children's Hospital and Health Center v. Belshe*, 188 F.3d 1090 (9th Cir. 1999). A petition for a writ of certiorari is currently

issue is found in HCFA's acceptance of New Jersey's State Plan Amendment specifically stating that New Jersey will not make DSH payments to out-of-state hospitals.[14]

Where Congress has not spoken to the precise question at issue, "the question for the court is whether the [Secretary's interpretation] is based on a permissible construction of the statute." *Chevron*, 467 U.S. at 842-43; *Queen of Angels*, 65 F.3d at 1477. A reviewing court need not conclude that the Secretary's interpretation of the statute is the "only reasonable one, or even the 'best' one[,]" *Queen of Angels*, 65 F.3d at 1477, and deference is due the Secretary's reasonable construction of a statute that she administers. *Id.*; *see also Rosado v. Wyman*, 397 U.S. 397, 406-07 (1970). "Confronted with an ambiguous statutory provision, we generally will defer to a permissible interpretation espoused by the agency entrusted with its implementation." *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 414 (1993) (citations omitted).

Similarly, where the Secretary's interpretation of her own regulations is reasonable, a reviewing court must defer to that interpretation. *Shalala v. Guernsey Mem. Hosp.*, 514 U.S. 87, 94-95 (1995); *see also Blum v. Bacon*, 457 U.S. 132, 141 (1982)("interpretation of any agency charged with the administration of a statute is entitled to substantial deference"); *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994); *Udall v. Tallman*, 380 U.S. 1, 16 (1965)("When the construction of an administrative regulation rather than a statute is in issue, deference is even more clearly in order."). Accordingly, the Secretary's administrative interpretation of her regulations must be given "controlling weight unless it is plainly erroneous or inconsistent with the

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pending, 68 U.S.L.W. 3595 (U.S. Mar. 9, 2000)(No. 99-1497).

[14] As HCFA explained in its *Amicus* brief in *Children's Hospital and Medical Center*, its interpretation of the statute is that states can make DSH payments to out-of-state providers, but they are not required to do so.

regulation." *Id.* at 16-17; *accord Thomas Jefferson Univ.*, 512 U.S. at 512.

Thus, as there is no statutory requirement to make DSH payments to out-of-state hospitals, this Court should defer to the Secretary's interpretation. As the Third Circuit noted, "federal approval of the amendment to the plan ... could foreclose a statutory argument challenging the denial of DSH payments." *Children's Seashore House*, 197 F.3d at 661.

C. The Obligation to Make DSH Payments is too Vague to be Judicially Enforced

Lastly, CSH also cannot meet the third prong of the test -- that the obligation is not too vague and amorphous to be judicially enforced. There simply is no longer any requirement in the statute and implementing regulations that the State make elaborate "findings" in order to give "assurances" to HCFA when seeking approval of a rate change. Contrary to the Boren Amendment requirements, there are no specific procedural or substantive requirements which must be met in either 42 U.S.C. § 1396a(a)(13)(A) or 42 U.S.C. § 1396r-4, or any payment standard contained within.

Under *Wilder*, the Supreme Court relied upon the specificity of considerations that the states had to review contained in the Boren Amendment, and measured the states' compliance against a benchmark of "reasonable and adequate" rates:

> [T]he statute and regulation set out factors which a State must consider in adopting its rates. For example, when determining methods for calculating rates that are reasonably related to the costs of an efficient hospital, a State must consider: (1) the unique situation (financial and

> otherwise) of a hospital that serves a disproportionate number of low income patients, (2) the statutory requirements for adequate care in a nursing home, and (3) the special situation of hospitals providing inpatient care when long-term care at a nursing home would be sufficient but is unavailable. 42 U.S.C. § 1396a(a)(13)(A) (1982 ed., Supp. V). In addition, the statute requires the State, in making its findings, to judge the reasonableness of its rates against the objective benchmark of an "efficiently and economically operated facilit[y]" providing care in compliance with federal and state standards while at the same time ensuring "reasonable access" to eligible participants. [*Wilder*, 496 U.S. at 519, and n. 17].

It is abundantly clear that with the repeal of the Boren Amendment, states are no longer required to review a laundry list of considerations and measure whether an efficient facility would be adequately reimbursed.

CSH argues that the criteria in 42 U.S.C. § 1396r-4 requiring a payment adjustment for DSH hospitals evidences Congress' intent that it should receive a DSH payment from New Jersey in addition to what it receives from Pennsylvania. Not only is there no statutory language which requires a state to make DSH payments to out-of-state providers, the statute does not even require any specific level of payment to any hospital, whether in-state or out-of-state. For example, a state can pay "a minimum specified additional payment" as long as the payment is "reasonably related" to "costs, volume, or proportion of services." 42 U.S.C. §

1396r-4(c)(3). This standard is clearly too vague and amorphous to be judicially enforced.

Having failed to establish the three prongs of the test for standing, it is clear that CSH has no standing to bring this action challenging New Jersey's failure to make out-of-state DSH payments as part of its hospital reimbursement scheme. Consequently, the decisions below were correct and there is no basis for granting this petition for a writ of certiorari.

II. There Is No Irreconcilable Conflict Among the Circuit Courts Meriting the Attention of this Court in this Matter.

Petitioner posits that certiorari should be granted because there is a conflict among the circuit courts as to whether hospitals may continue to seek recourse against states following the repeal of the Boren Amendment. However, there is no irreconcilable conflict meriting the attention of this Court.

The alleged conflict arises from the Ninth Circuit's decision in *Children's Hosp. and Health Ctr. v. Belshe, supra*, 188 F.3d 1090, wherein the court held that California must either have payment methodologies that had been validly determined under the Boren Amendment or that complied with the new public process requirements of the BBA. *Id.* at 1095. California did not adopt rates in compliance with the public notice requirements of the BBA. Therefore, the Ninth Circuit evaluated the rates to see if they complied with the Boren Amendment.

In contrast, the Third Circuit in deciding this matter did not apply the Boren Amendment and looked solely to the BBA. *Children's Seashore House*, 197 F.3d at 659.[15]

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[15] The other case cited by petitioner, *Hall v. Sullivan*, 129 F.3d 113, 1997 WL 643921 (2d Cir. 1997), is an unpublished opinion. In that matter the parties agreed that as of whatever date the Boren Amendment

Unlike the Ninth Circuit case, this matter was filed after the Boren Amendment was repealed and the BBA was already in effect. Moreover, on appeal to the circuit court, CSH abandoned its argument that the Boren Amendment applied to this matter and argued solely that the BBA and § 1923 gave rise to standing. Consequently, there is no basis for this Court to grant certiorari on the issue of whether the Boren Amendment still applies.

Furthermore, the Ninth Circuit did not even address the standing issue which is the basis of the Third Circuit's decision. The Ninth Circuit did not examine the three-prong test or make any determination as to whether the plaintiffs had standing to bring the suit under 42 U.S.C. § 1983. Thus, there is no direct legal conflict between the two decisions.

Additionally, even under the holding of the Ninth Circuit case, the ultimate outcome of this matter would not be different because New Jersey complied with the public notice requirements of the BBA. Contrary to California, following the enactment of the BBA, New Jersey complied with the new public process requirements of the BBA when it proposed an administrative regulation on April 6, 1998, which was adopted on June 18, 1998. 30 NJR 1258(a); 30 NJR 2653(a). Consequently, under either circuit court's analysis, the Boren Amendment is inapplicable and only the BBA applies to a determination of the issue.

Lastly, petitioner's argument based upon *Landgraf v. USI Film Products*, 511 U.S. 264 (1994), that the BBA should not be applied retroactively is equally unpersuasive. First, the BBA is not being applied retroactively because New Jersey complied with the BBA's public notice requirements after the BBA was enacted. Moreover, this case was filed after the BBA was enacted and after New Jersey complied with the BBA's requirements,

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was repealed, the appeal would be moot because there cannot be prospective relief to enforce requirements that have been repealed.

making the BBA the law in effect when the operative acts occurred. Further, as this Court noted in *Landgraf*, "[t]he first rule is that 'a court is to apply the law in effect at the time it renders its decision.'" *Id.* at 264 (citation omitted). This is especially appropriate when the intervening statute authorizes or affects the propriety of prospective relief. *Id.* at 275. In the case at bar, the only relief available is prospective injunctive relief.[16] Consequently, the court below was correct in applying the law in effect at the time it rendered its decision, which is the BBA.

Therefore, there is no need for this Court to grant certiorari in this case. The ultimate outcome would be the same whether analyzed based on the Third Circuit's decision or Ninth Circuit's decision. Moreover, the two cases are factually distinct and the reasoning utilized by the Third Circuit below complies with this Court's decision in *Landgraf*.

III. Social and Financial Significance Is Not a Basis for Granting Certiorari

Petitioner asserts that this Court should grant certiorari because DSH payments "implicate significant portions of state and federal budgets" and because there needs to be a method to ensure that states follow the requirements of § 1396r-4. However, these are policy issues that are best left to Congress.

Balancing the social and financial concerns raised by petitioner with the concerns faced by states under the Boren Amendment, Congress enacted the BBA. As noted above, the BBA does not require the payments petitioner seeks. Instead of seeking relief in the appropriate forum, *i.e.* Congress, petitioner is asking this Court to intervene in a

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[16] This is a 42 U.S.C. § 1983 matter against state officials acting in their official capacity only. Therefore, the Eleventh Amendment bars any monetary relief. *Will v. Michigan Dept. of State Police*, 491 U.S. 58 (1989)

policy, rather than legal, issue. Certiorari is simply unwarranted in such a case.

Furthermore, it is respectfully submitted that these policy factors do not change the analysis of whether § 1396r-4 creates a private cause of action. The test is not whether it would be a good thing to allow hospitals to contest their DSH payments. Rather, the test is whether the statute was intended to benefit the plaintiff; whether the provision imposes an unambiguous binding obligation; and whether the interest asserted is too vague and amorphous such that it is beyond the competence of the judiciary to enforce. *Blessing, supra*, 520 U.S. at 340-41. As demonstrated above in Point I, § 1396r-4 fails this test.

In addition, a private right of action is not necessary to ensure that states meet the requirements of § 1396r-4. The federal government still has oversight authority to make sure that states comply with federal law, and HCFA could take measures against any state that violated the provisions of § 1396r-4, including withholding payments. *See* 42 C.F.R. §§ 430.32, 430.33 and 430.35.

In sum, the "social and financial" considerations raised by petitioner do not warrant review of this matter by this Court, especially since the matter was correctly decided by the court below.

IV. There is no Need for this Court to Examine this Matter on an Interlocutory Basis

This matter is currently pending in the district court following the remand by the Third Circuit. Consequently, this appeal is of an interlocutory order.

Ordinarily, this Court will not issue a writ of certiorari to review an interlocutory order of the circuit court of appeals "unless it is necessary to prevent extraordinary inconvenience and embarrassment in the conduct of the cause." *American Construction Co. v. Jacksonville, T. & K. R. Co.*, 148 U.S. 372, 384 (1893). "[E]xcept in extraordinary cases, the writ is not issued until final decree."

Hamilton-Brown Shoe Co. v. Wolf Bros. & Co., 240 U.S. 251, 258 (1916).

The remand of this matter back to the district court by the circuit court is sufficient grounds for denial of this petition. *Ibid. See Brotherhood of Locomotive Firemen v. Bangor & Aroostook R. Co.*, 389 U.S. 327, 328 (1967)(denying certiorari because the Court of Appeals remanded the case, making it unripe for review).

As there is no final order in this matter and no unusual circumstances present in the case at bar, the petition for a Writ of Certiorari should be denied.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

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Dated: May 31, 2000